STATE OF MICHIGAN
JENNIFER M. GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

Enclosed is the allegation form you requested.

Also enclosed are two "Authorization For Release of Privileged/Client Information" forms for signature by the patient, his/her representative, or guardian, if the patient is a minor. **A sample release form is enclosed to assist you. Additionally, carefully read the following instructions to assist you in accurately filling out the forms:**

- Include the patient's date of birth and social security number, if applicable.
- Make sure the patient, his/her representative, or guardian signs and dates the form.
- Make sure the signature is witnessed at the same time.
- If you are signing this release on behalf of a patient who is not a minor child, you must provide us with a Letter of Authority, issued by the probate court, which empowers you to act on behalf of the patient.
- Do not include information for more than one doctor or hospital on the same release form. Doing so will make the form invalid.
- Do not make any additional markings and/or comments on the release form other than the information required. Doing so will make the form invalid.

Additionally, enclosed is a "Treatment Data" form. **This form should also be completed as indicated on the enclosed sample. It is important to include only the name of the doctors and/or hospitals which treated the patient for the same condition as stated on the allegation form.** This information is important and will assist us in obtaining the patient records related to the allegation. Please remember to supply treatment dates.

Please return the completed "Allegation Form" (you may keep the yellow copy of the form for your records), the "Authorization For Release of Proviledge/Client Information" form and the "Treatment Data" form. Upon receipt of the completed documents, your allegation will be reviewed and a determination will be made if licensing action should be considered.

If you have any questions in completing the enclosed forms, or if you need additional forms, please contact our office at the phone number listed below.

Complaint and Allegation Division
Bureau of Health Professions
Telephone: (517) 373-9196

Due to a recent court decision, the content of your allegation may be released; however, we will make every effort to protect your identity.

DCH/CAD-200 (8/04)

State of Michigan
Michigan Department of Community Health
Bureau of Health Professions
Complaint and Allegation Division
P.O. Box 30670
Lansing, MI 48909-8170
www.michigan.gov/healthlicense

Office Use Only
File #

ALLEGATION FORM

Authority: Public Act 368 of 1978, as amended.
Completion: Voluntary Penalty: None

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board do not assist citizens seeking return of their money or other personal remedies.** I am, however, submitting this information so that it may be determined if licensing action against this practitioner should be considered.

Instructions: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the white copy to the address at above. Retain the canary copy for your records.

Information About You		
Your Name		
Street Address		
City		
State	Zip Code	County
Patient's Name		
Your Telephone Number Home ( ) Work ( )		

Complaint Filed Against	
Practitioner's Name	
Street Address	
City	
State	Zip Code
Practitioner's Telephone Number ( )	
Treatment/Incident Date	

Check one:

- ❒ Audiologist
- ❒ Allopathic Physician (MD)
- ❒ Chiropractor
- ❒ Counselor
- ❒ Dentistry
- ❒ Marriage & Family Therapist
- ❒ Nurse (RN or LPN)
- ❒ Nursing Home Administrator
- ❒ Nurse Aide (CENA)
- ❒ Occupational Therapist
- ❒ Optometrist
- ❒ Osteopathic Physician (DO)
- ❒ Pharmacist
- ❒ Physical Therapist
- ❒ Physician's Assistants
- ❒ Podiatrist
- ❒ Psychologist
- ❒ Respiratory Therapist
- ❒ Sanitarian
- ❒ Social Worker
- ❒ Veterinarian

Is there court action pending? ❒ Yes ❒ No	Enter your attorney's name	May we release your name and this information to the practitioner? ❒ Yes ❒ No	Will you testify at an Administrative Hearing if necessary? ❒ Yes ❒ No

Give details of your concerns (who, what, when, where, how, etc... Use additional sheets if necessary).

Signature _____ Date _____

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health
Bureau of Health Professions
DCH/OHS-0206 (11/04)

FILE #: **** SAMPLE FORM ****

** SAMPLE ** TREATMENT DATA FORM

NAME OF PATIENT: Mary Smith

Date of Birth: 01/01/1950 Social Security Number: 123-45-6789

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: John Doe, M.D.
ADDRESS: 123 Main Street
CITY/STATE/ZIP: Lansing, MI 48910
TELEPHONE: (517) 361-9898
Dates of Treatment:
Beginning: May 2001
Ending: September 2001

FULL NAME: Good Samaritan Hospital
ADDRESS: 789 First Street
CITY/STATE/ZIP: Lansing, MI 48912
TELEPHONE: (517) 361-5476
Dates of Treatment:
Beginning: August 15, 2001
Ending: August 31, 2001

FULL NAME:
ADDRESS:
CITY/STATE/ZIP:
TELEPHONE:
Dates of Treatment:
Beginning:
Ending:

FULL NAME:
ADDRESS:
CITY/STATE/ZIP:
TELEPHONE:
Dates of Treatment:
Beginning:
Ending:

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Completion: Voluntary Penalty: None

Authority: P.A. 368 of 1978, as amended.

Michigan Department of Community Health
Bureau of Health Professions
DCH/OHS-0206 (11/04)

FILE #: _____

TREATMENT DATA FORM

NAME OF PATIENT: _____

Date of Birth: _____ Social Security Number: _____

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: _____ Dates of Treatment:

ADDRESS: _____ Beginning: _____

CITY/STATE/ZIP: _____ Ending: _____

TELEPHONE: _____

FULL NAME: _____ Dates of Treatment:

ADDRESS: _____ Beginning: _____

CITY/STATE/ZIP: _____ Ending: _____

TELEPHONE: _____

FULL NAME: _____ Dates of Treatment:

ADDRESS: _____ Beginning: _____

CITY/STATE/ZIP: _____ Ending: _____

TELEPHONE: _____

FULL NAME: _____ Dates of Treatment:

ADDRESS: _____ Beginning: _____

CITY/STATE/ZIP: _____ Ending: _____

TELEPHONE: _____

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Completion: Voluntary Penalty: None

Authority: P.A. 368 of 1978, as amended.

DCH/CAD-HPR-0207 (3/04)

File Number: *** SAMPLE ***

*** SAMPLE ***

State of Michigan
Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

*** SAMPLE ***

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, Mary Smith, hereby authorize John Doe, M.D.
(Patient/Client/Representative's Name) *(Doctor/hospital/program or other custodian of record name)*

1234 Main Street, Lansing MI 48910
(Address of doctor/ hospital/ program or other custodian of records)

to release/exchange information contained in the records of:

Mary Smith	01/01/1950	123-45-6789
Patient Name	Date of Birth	Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
Michigan Department of Community Health (MDCH), Bureau of Health Professions, Complaint and Allegation Division, P.O. Box 30670, Lansing, Michigan 48909 or the Department of Attorney General.

2. **Specific type of information to be disclosed**:
Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

3. **The purpose and need for such disclosure**:
I understand that the Department of Community Health, Bureau of Health Professions and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that if I give MDCH permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Community Health, 320 S. Walnut, Lansing, Michigan 48913. I also understand that MCDH cannot take back any uses or disclosures already made with my permission. Unless otherwise revoked or if I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.

5. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

A copy of this authorization shall serve in the stead of the original.

Mary Smith
Patient/Client or Representative's Signature
(If signed by a Legal Representative, relationship to the Patient/Client. A letter of authority may be requested)

12-17-2003
Date Signed

Tim Smith
Witness' Signature

12-17-2003
Date Witnessed

12-17-2003
Date Prepared

This authorization is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45 CFR, Parts 160 & 164, as modified December 11, 2003. If you need assistance with reading, writing, hearing, etc., under the Americans with Disability Act, you may make your needs known to this Agency.

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

DCH/CAD-HPR-0207 (3/04)

State of Michigan
Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

File Number: _____

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, _____, hereby authorize _____
(Patient/Client/Representative's Name) *(Doctor/hospital/program or other custodian of record name)*

_____
(Address of doctor/ hospital/ program or other custodian of records)

to release/exchange information contained in the records of:

_____
Patient Name Date of Birth Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
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A copy of this authorization shall serve in the stead of the original.

_____ _____
Patient/Client or Representative's Signature
(If signed by a Legal Representative, relationship to the Patient/Client. A letter of authority may be requested)
Date Signed

_____ _____
Witness' Signature
Date Witnessed

_____
Date Prepared

This authorization is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45 CFR, Parts 160 & 164, as modified December 11, 2003. If you need assistance with reading, writing, hearing, etc., under the Americans with Disability Act, you may make your needs known to this Agency.

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended